



Performance Report ***Performance Period July 2003-September 2003***

Introduction

This report presents information about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD) during the first quarter of fiscal year 2004 (July 2003-September 2003), and is based on the most current data available. Where possible, data are aggregated at both statewide and district or complex levels.

Data are presented in four major areas: Population, Service, Cost, and Performance Measures. Population information describes the characteristics of the children, youth, and families that are served. Service information is compiled regarding the type and amount of direct care services that are used by children, youth, and families. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are tracked to understand the quality of services and the performance of operations of the statewide infrastructure needed to provide supports for children, youth, and families. Outcomes are further examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth and families.

Criteria for Establishing Measures

CAMHD Performance Measures are established through two criteria. The first is the reporting of measures directly linked to former Benchmarks and regular reports previously required by the Federal Court to gauge compliance with the Felix Consent Decree. By December 2002, all CAMHD Benchmarks reported to the Court were deemed to be “completed” or “completed and ongoing.” These CAMHD Performance Measures are tied to demonstrating sustainability with the gains made during the Felix Consent Decree. The Benchmarks and reports to the Court were:

- 1) CAMHD outcome and results components will be implemented (Benchmark 22),
- 2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26),
- 3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative...CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed),
- 4) Personnel and Vacancy Reporting,
- 5) Benchmarks that describe complex-based service testing, and

- 6) Complaints (no Benchmark attached, reporting requested by the Felix Monitoring Project).

The second standard for choosing CAMHD Performance Measures is the selection of indicators that align CAMHD performance with achieving results in core areas of service provision and supporting infrastructure. Measures are chosen to coordinate the work of the organization in order to achieve timely, cost-effective services that improve the lives of children, youth and families served. Although not all indicators link directly to former Court Benchmarks, they are measures of a sustainable system of children's mental health services.

Use of Performance Data in CAMHD

Decision-making and aligning work with improvement objectives

Performance measurement serves to communicate the objectives and overall performance requirements of CAMHD's strategic goals throughout its organization. They provide data-driven information that allows for the evaluation of quality and results through objective data. Tracking of measures organizes work around objectives, and promotes accountability for organizational performance results. Because performance data in CAMHD are continuously tracked and readily available, decisions about services and adjustments to program implementation can be made quickly and accurately, a key advantage in serving youth with intensive mental health issues.

A primary use of data is to inform continuous improvement efforts at all levels. CAMHD's internal quality management structure includes a Performance Improvement Steering Committee (PISC) that reports to the CAMHD Executive Management Team. PISC and its subcommittees receive performance data and reports regarding the quality and effectiveness of care across the service system, and recommend the implementation of accountable improvements throughout the organization and service system. Performance reporting about client status, care and service delivery is assessed to determine priorities for improvement, including areas that would benefit from focused study. The PISC monitors and evaluates actions taken to improve performance.

Decision support and clinical analysis are further enhanced through the use of "live" data through the Child and Adolescent Mental Health Management Information System (CAMHMIS). Relevant client-related data including functional outcomes, service history, and current interventions are displayed in profile formats, which assist Care Coordinators and teams in service planning.

Feedback to staff regarding performance

At both the Central CAMHD Office and the Family Guidance Centers (FGCs), Branch Chiefs and supervisors are able to access timely data relevant to unit and staff performance. Local-level managers are also able to monitor regional and statewide trends and performance expectations, which further supports planning and decisions. The use of data and focus on results has become an organizational value, and is evident in daily operations at all levels. Performance measure selection and tracking is now entering its fourth full year of implementation in all units of the organization. This has allowed staff to link their own work processes to strategic outcomes and results. Performance

measurement also extends to the CAMHD provider network, which systematically track performance data on selected functions.

Accountability to stakeholders

The tracking and reporting of performance data allow CAMHD stakeholders to view the core aspects of service delivery and performance of the mental health service system for children, youth and families. Representatives of CAMHD provider network and families participate on the majority of CAMHD committees, including PISC, and provide invaluable input into CAMHD improvement initiatives.

Data Sources

The primary source for data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through CAMHMIS. CAMHMIS has the ability to produce data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data as earlier described, FGC-specific reports and a host of special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data reflect the first quarter of fiscal year 2004 (July-September 2003) for youth registered in the CAMHD Family Guidance Centers. In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,642 youth across the State, a decrease of 152 from the previous reporting quarter (April-June 2003), or an 8% decrease in the total population.

The total number of registered youth are described by four subgroups: (i) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (ii) youth who were in the process of having services arranged (new admissions), (iii) youth who received less intensive services through Mokihana on Kauai, and (iv) youth who were discharged at some time during the quarter. There was also a percentage of youth who received intensive case management services only. Of the total registered youth, 844 had services that were authorized within the quarter.

Of the registered population (1,642), 85 youth (5.2%) were newly registered in the first quarter of fiscal year 2004. This represents a decrease in 58 new admissions from the fourth quarter. Ninety-three (93) youth (5.7%) who had previously received services from CAMHD were reregistered in CAMHMIS, a slight decline from last quarter's readmissions of 107 youth. CAMHD discharged a total of 164 youth during the quarter or 10.0% of the registered population. This is a decline from last quarter's discharge of 238 youth (13.3% of the registered population).

Of the 844 youth who had services authorized in the quarter, 28 were new admissions (3.3%), 24 repeat admissions (2.8%) and 57 discharges (6.8%). There were 29 more youth with services authorized discharged than admitted in the period. It is important to note that because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth registered in the reporting quarter was 14.5 years with a range from 3 to 20 years. As displayed in Table 1, the majority of the youth were male (67%).

Table 1. Gender of CAMHD Youth

Gender	N	% of Available
Females	537	33%
Males	1,105	67%

A large percentage of youth who receive case management and direct services through CAMHD are involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 2). Of the youth who had services authorized in the quarter, 16.9% were involved with DHS, 37.3% had a Family Court hearing during the quarter, and 11.4% were incarcerated at HYCF or detained at the Detention Home. QUEST-eligible youth who received services in the quarter were

Table 2. Agency Involvement of Youth with Authorized Services

Agency Involvement	N	%
DHS	143	16.9%
Court	315	37.3%
Incarcerated/Detained	96	11.4%
Quest	331	39.2%

39.2% of the population who received services through the CAMHD provider network.

CAMHD continues to receive Federal Medicaid reimbursement to provide behavioral health services within the CAMHD array of services under the Medicaid state plan for rehabilitative services. A key provision of the Memorandum of Agreement with the Med-QUEST Division allows any QUEST-eligible youth with Severe Emotional and Behavioral Disturbance to receive services through CAMHD. A child's Quest Health plan, child-serving agency or other referral sources can directly refer youth for a determination of eligibility for intensive mental health services. Because a growing segment of the Medicaid population are children and youth with psychiatric disabilities, access to CAMHD services is critical for eligible children and youth with severe and chronic mental health issues.

Table 3 describes the various ethnicities of youth who received authorizations for services in the reporting quarter. Those with Mixed ethnicities represented the largest group (30.1%), closely followed by youth of Hawaiian ethnicity (21.7%). Caucasian made up the third largest ethnic group (20.9%), followed by Filipino (7.9%) and Japanese (5.4%).

Table 3. Ethnicity of Youth with Authorized Services

Ethnicity	N	% of Available
African-American	22	3.0%
African, Other	2	0.3%
American Indian	2	0.3%
Asian, Other	8	1.1%
Caucasian, Other	155	20.9%
Chamorro	0	0.0%
Chinese	3	0.4%
Filipino	59	7.9%
Hawaiian	161	21.7%
Hispanic, Other	9	1.2%
Japanese	40	5.4%
Korean	2	0.3%
Micronesian	2	0.3%
Mixed	224	30.1%
Pacific Islander	12	1.6%
Portuguese	18	2.4%
Puerto Rican	8	1.1%
Samoan	16	2.2%
Not Available	101	12.0%

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 4). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with authorized services in the quarter were disruptive behavior disorders (50.8%), attentional disorders (39.9%), and mood disorders (38.6%). This is similar to the previous quarter when the diagnostic profile for the top three diagnoses was disruptive behavior disorders (49.2%), attentional disorders (39.9%) and mood disorders (37.4%).

Table 4. Diagnostic Distribution of Youth with Authorized Services

Any Diagnosis of	N	%
Disruptive Behavior	429	50.8%
Attentional	337	39.9%
Mood	326	38.6%
Miscellaneous	212	25.1%
None Recorded	165	19.5%
Anxiety	145	17.2%
Substance-Related	128	15.2%
Adjustment	93	11.0%
Deferred	87	10.3%
Mental Retardation	16	1.9%
Pervasive Developmental	2	0.2%

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Those youth with miscellaneous diagnoses account for 25.1% of the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control and eating disorders. Many youth in the population have co-occurring, or more than one diagnosis. In the reporting quarter 65.4% of registered youth had more than one diagnosis, with an average of 1.8 diagnoses per youth (median=2). Youth with substance-related diagnoses represent 15.2% of the population. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use as a target of intervention.

Services

The tracking and analysis of services that are provided is a vital function in any service system for a number of reasons. Tracking of utilization of the services within the CAMHD array allows for accurate accounting and data-driven planning and decision-making. Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. On the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (July-September 2003). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive services provided in the home and/or community, which consist of Intensive In-home services (46.0%) and Multisystemic Therapy (15.4%). The largest group of youth in an out-of-home setting received services in a Community-based Residential program (18.5%). Youth receiving treatment while in Therapeutic Family Homes accounted for 14.3% of those served, and Therapeutic Group Homes 11.6%.

Table 5. Service Authorization Summary (July 1, 2003-September 30, 2003).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	5	5	0.3%	0.6%
Hospital Residential	14	25	1.5%	3.0%
Community High Risk	9	9	0.5%	1.1%
Community Residential	118	156	9.5%	18.5%
Therapeutic Group Home	75	98	6.0%	11.6%
Therapeutic Family Home	104	121	7.4%	14.3%
Respite Home	1	2	0.1%	0.2%
Intensive Day Stabilization	0	0	0.0%	0.0%
Multisystemic Therapy	101	130	7.9%	15.4%
Intensive In-Home	314	388	23.6%	46.0%
Flex	102	164	10.0%	19.4%
Respite	15	19	1.2%	2.3%
Less Intensive	5	9	0.5%	1.1%
Crisis Stabilization	2	5	0.3%	0.6%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

Flex services were provided for 19.4% of youth served. Flex services are a broad category that range from mental health services not provided through a regular purchase of service contract, to travel for youth in off-island residential programs, to interpretive services. The pattern of relatively few families receiving Respite services continued with only 2.3% of the served population accessing this service in the reporting quarter.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the fourth quarter of fiscal year 2003 (April 1, 2003-June 30, 2003). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 6. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment accounted for 83.4% of service expenditures. This compares to out-of home service accounting for 81.9% of the total costs in the third quarter of FY 2003, or a 1.5% increase in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 1.6% of total expenditures.

Table 6. Cost of Services

Any Receipt of Services	Total Cost (\$)	Cost per Youth (\$) ^a	Cost per LOC (\$) ^b	Cost per LOC per Youth (\$) ^b	% of LOC Total (\$) ^b
Out-of-State	149,188	24,865	149,188	24,865	1.6%
Hospital Residential	793,772	30,530	621,875	23,918	6.5%
Community High Risk	450,672	45,067	387,585	38,759	4.1%
Community Residential	4,009,857	25,062	3,482,449	21,765	36.5%
Therapeutic Group Home	2,148,475	19,711	1,800,090	16,515	18.9%
Therapeutic Family Home	2,035,560	15,078	1,655,325	12,262	17.4%
Respite Home	13,053	6,526	800	400	0.0%
Intensive Day Stabilization	40,638	8,128	8,500	1,700	0.1%
Multisystemic Therapy	1,065,768	5,639	607,868	3,216	6.4%
Intensive In-Home	1,638,730	3,958	671,213	1,621	7.0%
Flex	3,401,330	20,490	113,061	681	1.2%
Respite	67,088	2,580	18,356	706	0.2%
Less Intensive	263,733	13,187	18,265	913	0.2%

Note: ^a Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. ^b Cost per LOC represents unduplicated cost for services at the specified level of care.

Hospital-based Residential Services experienced a decreased cost in the reporting quarter while costs for Community-based Residential Services increased. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the highest total cost per youth (\$45,067 per youth, with an average of \$38,759 per youth expended for Community High-Risk Services only). For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes (\$15,078 per youth).

In-home (Intensive In-home and MST) and less intensive services accounted for 13.6% of the unduplicated cost of services, which was slightly higher than the last reporting quarter (April-June 2003) percentage of total costs for those categories. Youth receiving Intensive In-home services at some point during the quarter cost an average of \$3,958 per youth (\$1,121 for Intensive In-home service only), which continues to be significantly less than the cost per any youth in a residential program. Due to manual billings for youth who receive in excess of the Performance Standard for this service, this number is an underestimate of the true cost for youth at this level of care. Historically, average Intensive In-home expenditures have tended to approximate MST averages, while total costs tend to exceed MST total costs due to the larger number of served youth.

Youth who received Flex services during the quarter had a cost of \$20,490 per youth, or a cost just in this level of care of \$681 per youth. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for flex services suggest that youth in out-of home placements account for a high percentage of youth receiving flex services.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and family guidance centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youth with mental retardation and/or developmental disabilities who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD in order to provide youth with the most appropriate individualized supports consistent with national best practices in developmental disabilities. An MOA between CAMHD and DDD for fiscal year 2004 to continue the provision of services, supports and coordination for these youth was executed in July 2003.

Respite Services

For July, August, and September, respite services for the majority of the target population transitioned to the DDD service system. From July 2002 through the present, families participated in the person-centered planning process with the DOH DDD case manager, including being informed about the services and supports available through DDD funding. Families and case managers have worked to transition into other service options such as DDD Respite (via open enrollment), Home and Community Based Services DD/MR waiver program (HCBS-DD/MR), and other DDD funded supports such as our Purchase of Service (POS) Partnerships in Community Living (PICL) or the Family Support Services Program (FSSP). As seen in Table 7 below, families utilized various DDD services.

Table 7. Other Service Options Utilized by CAMHD Respite Recipients

DDD Service	# of Users
*HCBS – DD/MR Waiver	35
*POS - Partnerships in Community Living (PICL)	41
*DDD Respite	90
Family Support Services Program (FSSP)	15

* Waiver admission as of 09/23/03

* PICL referrals for period 07/01/02 – 09/30/03

* DDD Respite (CAMHD recipients who applied for DDD Respite in June 2003)

In summary, of the original 205 youth identified in the MOA, 132 families (123 from the original list plus 9 youth later identified), or 64% were identified by DDD as eligible and in a position to receive respite supports. The remaining 91 families did not receive respite for a variety of reasons including lack of documentation of need, lack of response, declined respite, moved out of state, or aged out of services.

Although authorized for respite, eight (8) families did not submit invoices for reimbursement. These 8 families completed ISPs and signed authorization forms with the DOH DDD case manager but did not submit invoices. Families were notified about the available respite by means of 1) letters mailed in April 2003 and May 2003; 2) newsletter of May 2003; and 3) DOH DDD case manager contacts. Guardians for all six (6) youth living in foster families (of the original 205 youth) were contacted. Two (2) of the youth in foster care were authorized funding and utilized respite. Table 8 below presents total expenditures for youth receiving DDD services by island since July 2002.

Table 8. Expenditures to Date for CAMHD Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	\$145,611.18	46%	\$1994.67
Hawaii	34	26%	\$89,564.00	28%	\$2634.24
Kauai	11	8%	\$54,174.50	17%	\$4924.95
Maui	14	11%	\$27,258.00	9%	\$1947.00
Total Youth	132	Total Dollars Expended (As of 07/01/02 – 09/26/03)			\$316,607.68

The transition of CAMHD Respite into the DDD service system has been communicated in a variety of ways including: 1) authorization form initially signed by every participating CAMHD family which states transition period dates of 07/01/02 – 06/30/03; 2) community meetings; 3) letters mailed to all participants on 05/16/03; 4) newsletter of May 2003; 5) case manager contacts; 6) respite coordinator contacts; and 7) ISPs.

Residential Services

Since the last performance period, an additional youth “aged out,” leaving ten (10) clients served through the current POS contract, Individualized Community Residential Supports (ICRS). The last report (Performance Period April 2003 - June 2003) incorrectly reported that 10 out of 11 youth served in the contract as being admitted into the HCBS-DD/MR waiver program. The correct number should have been 8 out of 11. To date, nine (9) out of ten (10) clients served in the ICRS contract have been admitted into the HCBS-DD/MR waiver program. The one client who is not in the HCBS DD-MR waiver is in a hospital-based residential setting.

There were two residential changes during this performance period for youth served in the ICRS contract. One (1) youth moved out of an independent living situation and back to the original respite home. One (1) youth was moved to another foster home after the initial foster placement did not meet licensing requirements. The remaining eight youth covered in the ICRS contract continue to live in the same settings.

Latest Child and Family Services (CFS) and DOH DDD Case Manager reports indicate consistent school attendance in accordance with IEPs for 9 out of the 10 youth. For FY 2004, the Individual Community Residential Support (ICRS) contract with Child and Family Service is for \$986,390.00.

Joint Training Initiative

Based on findings of last quarter’s CAMHD review of DDD Respite and Residential Services for the target population, several joint initiatives were launched. The review recommendations included building skills in case management and service provision for youth with developmental disabilities and co-occurring mental health issues, particularly those with problematic sexual behaviors. A joint training on providing services for the youth with developmental disabilities and sexualized behaviors has been scheduled for November 2003, to include an overview of the population, continuum of behaviors,

assessment and interventions. Initial discussions have been held to share elements of the CAMHD Care Coordination Training Curriculum, and to identify opportunities for integrating aspects of these trainings into DDD core training curricula.

Overall Supports for the Population

Since last quarter's report (April to June 2003) DOH/DDD has undertaken accelerated capacity building to address the recommendations in the last report. This has taken the form of:

- 1) Contracting in July with a prominent autism specialist from the University of Arkansas Medical Sciences, Department of Pediatrics to train DOH/DDD case managers statewide in the service needs of children with autism, meeting with parents or parent advocacy groups on each of the neighbor islands to solicit their concerns and input regarding service needs for children with autism and their families, and agency providers for their concerns regarding transition planning for children with DD/MR leaving the DOE;
- 2) DOH/DDD contracted with a developmental pediatrician on Maui to provide consultation and technical assistance to DDD case management and families on Maui, and began participating in monthly CAMHD Medical Directors meetings, as well as recently completing training in the DDD case management system;
- 3) A psychologist was recently hired into a full time position who is a specialist in children with developmental disabilities, particularly autism, who will provide consultation, technical assistance and participate in the cross training between CAMHD and DOH/DDD, as well as collaborate with the Center on Disability Studies (CDS) in projects central to DDD, and is a certified behavior analyst for functional assessments and behavior support plans;
- 4) The DOH/DDD program support training coordinator has been assigned, and presently collaborating with the CAMHD training coordinator, to shape necessary in-service training vital to the joint training of both CAMHD care coordinators and DOH/DDD case managers; and
- 5) DOH/DDD is in its second year of a National Core Indicator Project (NCIP) to improve performance starts and measure agency performance in service delivery. Hawaii is one of 16 states participating in the NCIP conducts on-going face-to-face interviews with clients, families and guardians to assure health, safety and welfare. In addition, the DOH/DDD Ombudsman is in position to monitor and track concerns and issues regarding service coordination and delivery, as well as serves as third party mediators upon request and provides referral and education as appropriate. Collectively the NCIP and the Ombudsman Office provides families and consumers objective and neutral means of having needs addressed.

Performance Measures

CAMHD's performance measures gauge sustainability of services and results, and demonstrate the adequacy of services, infrastructure, and key practice initiatives at a level needed. They measure the ability to maintain gains made since the inception of the Felix Consent Decree, and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

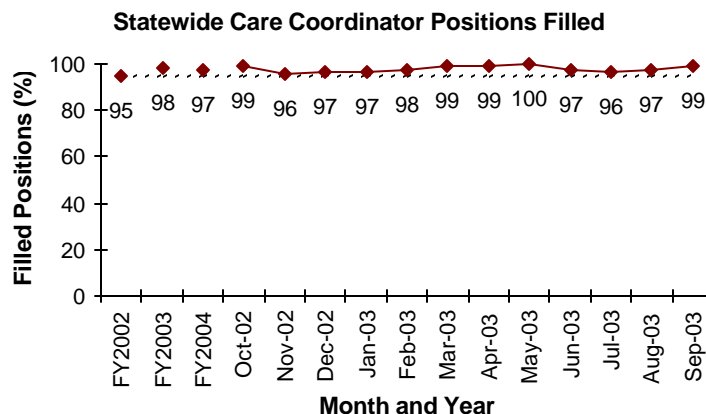
Those performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇒ **95% of mental health care coordinator positions are filled***

Over the reporting period, CAMHD continued to demonstrate a positive trend with an average of 97% of care coordinator positions statewide filled, exceeding the performance goal. At the end of the reporting period (September 2003), Family Guidance Centers had 99% of positions filled. This indicator measures the capacity of the Family Guidance Centers to provide intensive case management services for children and families.

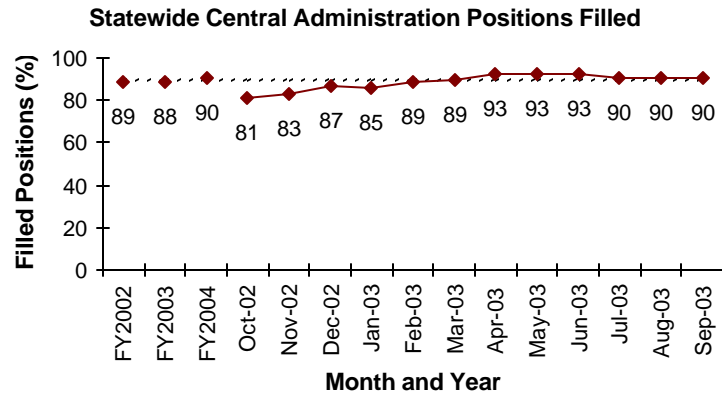


Goal:

⇒ **90% of central administration positions are filled***

The performance target was met with an average of 90% of central administration positions filled over the quarter. Central administration positions provide the infrastructure and quality management functions necessary to manage the statewide service system. Vacancies were

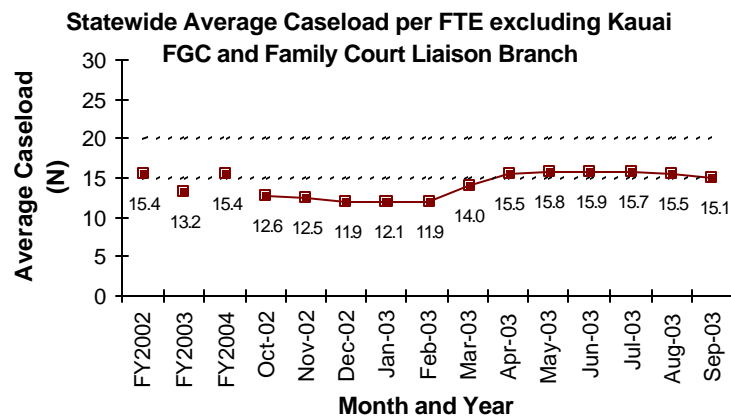
experienced in the Performance Management and Clinical Services Offices, but most positions were successfully recruited for, and offers were extended by the end of the quarter.



Goal:

⇒ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

The average caseload for the fourth quarter was within the target range at 15.4 youth per full time care coordinator equivalent (FTE). As explained in last quarter's report, CAMHD has decided to continue using the historical indicator of the average and to examine the caseload distribution across centers rather than individuals. CAMHD expects that care coordinator caseloads fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services.



Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
1 st Quarter Average	17	17	17	13	14	15

The average caseloads were met for all FGCs with the exception of Windward FGC and Honolulu FGC. This calculation of average excludes Kauai, who serve both high-end and low-end youth through the Mokihana project and therefore tend to have higher caseloads. Family Court Liaison Branch is also excluded because staff there provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight.

Goal:

⇒ Sustain within quarterly budget allocation

In the reporting quarter, the total variance from the budget was under projection by \$1,078,000. CAMHD continued its trend of sustaining below the budget allocation in the quarter. Branch, Central Office and Service expenditures were all below budget. The lower costs have resulted from several continuing trends including a smaller registered population, lower utilization of very high-end services (i.e., out-of-state and hospital-based residential), and systematic monitoring of performance standards and practice guidelines.

Variance from Budget (in \$1,000's)

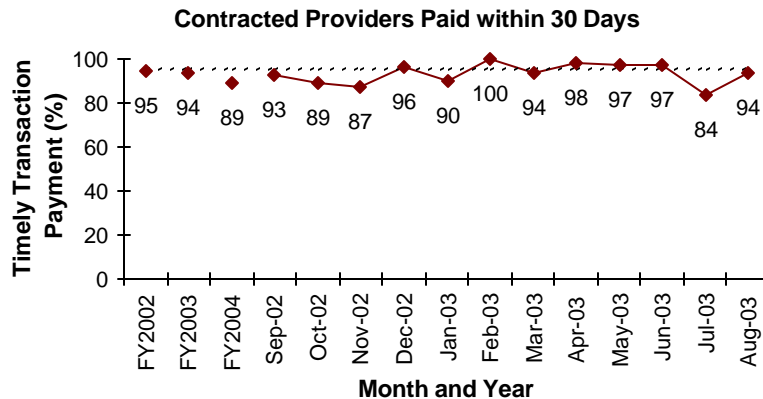
	FY 2002		FY 2003							
	Average	Average	2002.1	2002.2	2002.3	2002.4	2003.1	2003.2	2003.3	2003.4
Branch Total	\$164	-\$150	\$82	\$153	\$290	\$130	\$66	-\$195	-\$312	-\$162
Services Total	\$798	-\$4,175	\$1,487	-\$84	\$501	\$1,287	\$315	\$2	-\$16,251	-\$765
Central Office Total	-\$189	-\$388	-\$254	\$55	-\$535	-\$25	-\$833	-\$216	-\$352	-\$151
Grand Total	\$773	-\$4,713	\$1,315	\$128	\$256	\$1,392	-\$452	-\$408	-\$16,915	-\$1,078

CAMHD will maintain timely payment to provider agencies

Goal:

⇒ **95% of contracted providers are paid within 30 days**

The target goal not met as 89% of contracted providers were paid within the 30-day target. The average amount of time was 84% in July, where performance fell below the target due to manual billing delays for eleven invoices. August data showed rebounding performance with 94% of providers paid within the 30-day goal. As standard for reporting, data is only available for the months of July and August, as September's payments are still in mid-cycle. Improvement strategies have been implemented to remedy the manual billing delays. Beginning with the new fiscal year, CAMHMIS has been revised to allow for electronic overrides for billing outliers. This new feature should reduce the demand for manual billing. Beginning in October, CAMHMIS will launch its new HIPAA compliant transaction system. As with all major procedural transitions, a period of disrupted performance might be evident during the early months of the transition.

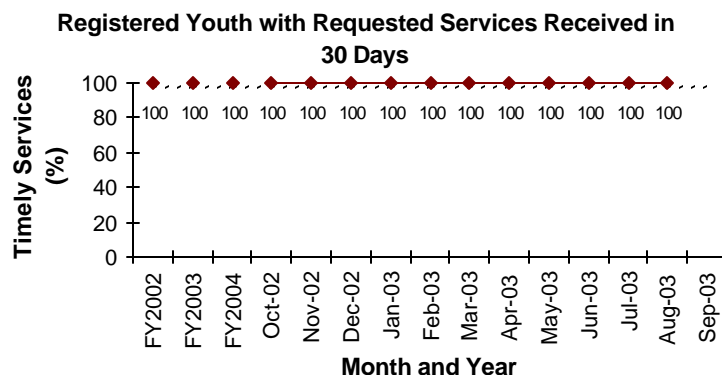


CAMHD will provide timely access to a full array of community-based services

Goal:

⇒ **98% of youth receive services within thirty days of request***

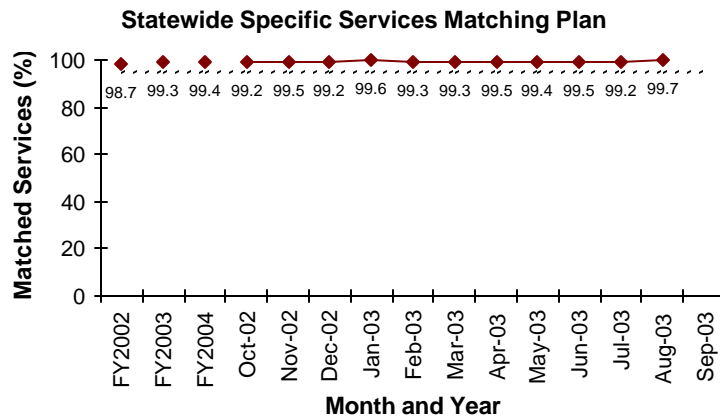
The goal was met for the quarter with 100% of youth receiving services provided timely access to those services. The last reported service gap was in August of 2001.



Goal:

- ⇒ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. In the quarter 99.4% of youth received the specific services identified by their team plan. In the third quarter, service mismatches occurred in ten complexes. These youth received services within 30 days, but they were not the exact service prescribed by their IEP teams. One complex, Baldwin, had four mismatches. Baldwin also experienced a number of mismatches in the last quarter (six). The remaining nine complexes had one mismatch. Baldwin Complex's mismatches continue to be attributed to a shortage of intensive in-home providers on Maui. CAMHD is working with the provider agency to assure an adequate number of providers for this service.

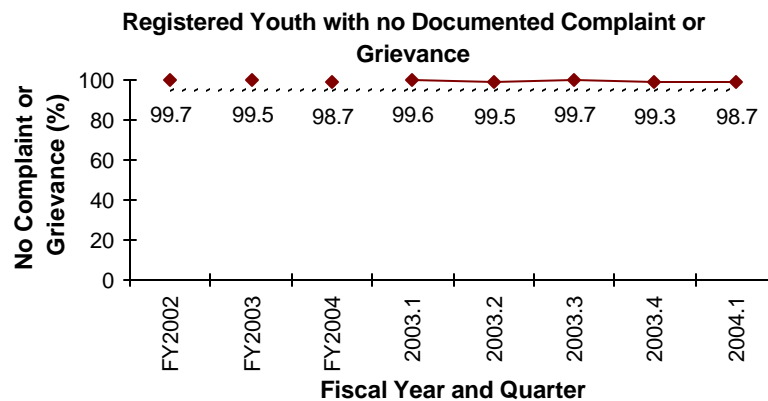


CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

- ⇒ 95% of youth served have no documented complaint received*

98.7% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers.



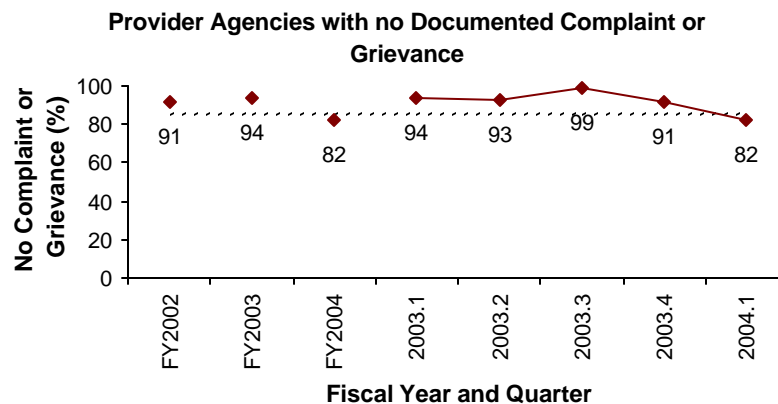
Previous reporting had included only youth where complaints were filed with the CAMHD Central Grievance Office. CAMHD revised its statewide

grievance management system so that reporting now includes complaints filed and resolved by Quality Assurance Specialists in the FGCs. Therefore, it is expected that the number of grievances recorded will continue to increase into the next quarter as the new methodology is fully implemented. CAMHD conducted extensive training on its Statewide Grievance System in the quarter, and distributed a new Consumer Handbook, that informs families of their rights and responsibilities. There were 22 youth with documented complaints representing thirteen complexes: Aiea, Kahuku, Kailua, Waianae, King Kekaulike, Molokai, Hilo, Keaau, Pahoa, Waiakea, Honokaa, Konawaena and Kau.

Goal:

⇒ **85% of provider agencies have no documented complaint received***

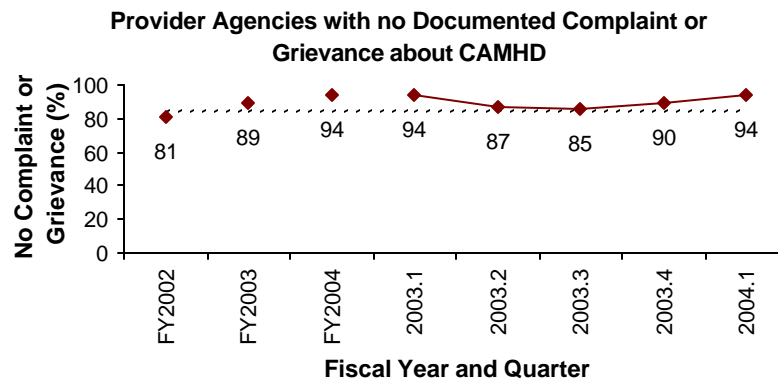
82% of provider agencies had no documented complaint about their services, which is slightly below the goal. As explained above, CAMHD has recently expanded its scope of its Grievance System to include complaints or grievances received both in its Central Office, as well as at any of the Family Guidance Centers. This statewide approach was adopted to comply with provisions of the Balance Budget Act, which CAMHD came into full compliance with in August 2003. The statewide Grievance management system allows for a wider source of data regarding CAMHD performance.



Goal:

- ⇒ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 94% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. This measure consistently met the performance goal for the past year.

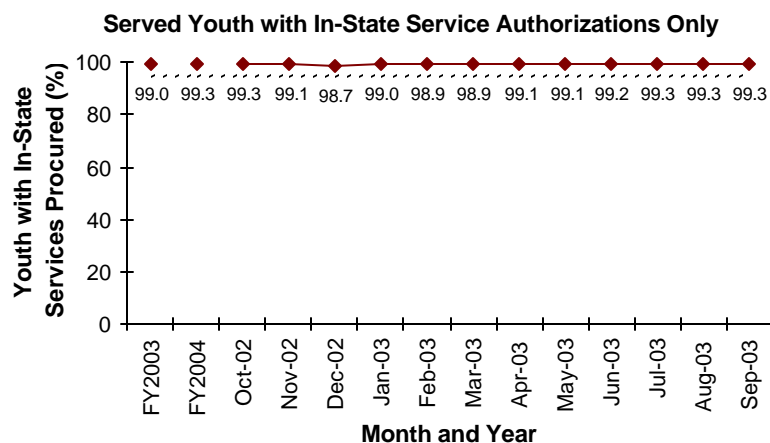


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting.

Goal:

- ⇒ 95% of youth receive treatment within the State of Hawaii*

In the quarter, an average of 99.3% of youth served received treatment within the State, which exceeds the goal. Five youth are receiving services in out-of state treatment settings, which is the same as last quarter.

**Goal:**

- ⇒ 65% of youth are able to receive treatment while living in their home

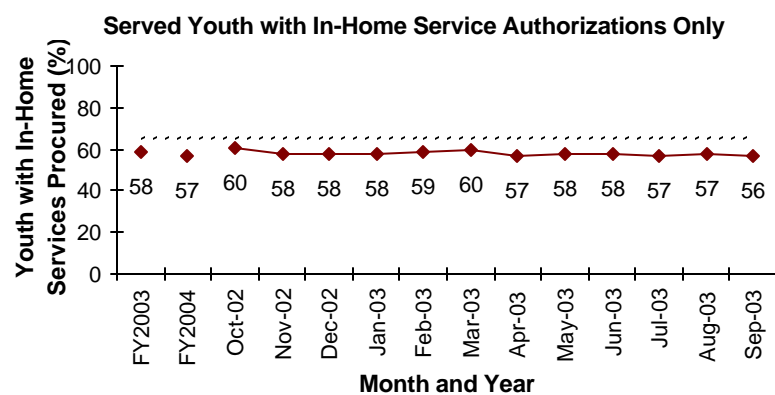
The quarter's data showed that 57% of youth were served in their home communities throughout the quarter, which did not meet the

performance goal of 65%. The goal was met for Windward and Honolulu FGCs, and nearly met for Central FGC.

This performance goal has been adjusted to reflect the actual service utilization patterns of youth with intensive needs as has been discussed extensively in past reports. The baseline trend for youth receiving services while living in their homes averaged 58% of the CAMHD population throughout FY 2003.

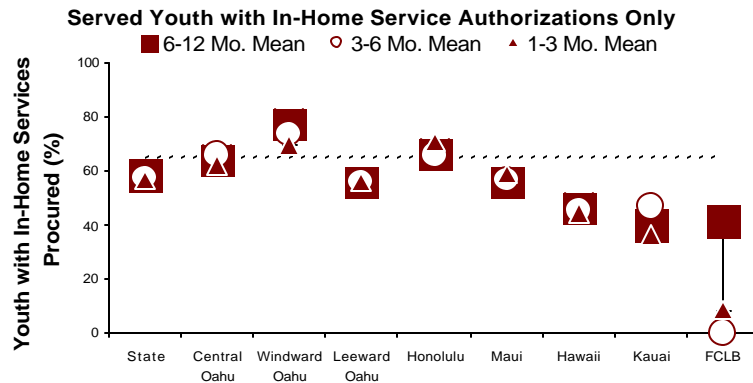
The performance benchmark for the proportion of youth served in their homes was originally selected when the CAMHD population included youth with pervasive developmental disorders (PDD). During the transition from fiscal year 2002 to 2003, the state transferred services for youth with PDD to the Department of Education and the Developmental Disabilities Division. As noted in earlier performance reports, since that time, CAMHD has questioned the appropriateness of the 75% benchmark for its current client population.

This quarter CAMHD completed an in-depth analysis of in-home services for youth with and without PDD over the past 27 months. This analysis suggested that using a performance target of 65% with the current CAMHD population would be comparable to the target of 75% in the fiscal year 2002 population, which included youth with PDD. Therefore, the performance target was revised to 65%. This change represents a population adjustment, not a reduced expectation for the provision of in-home services. When this new target is applied to the current population, CAMHD in-home service performance remained below expectations and was lower than the population-adjusted performance for fiscal year 2002.



As was discussed in the last quarterly report, the indicator is not completely sensitive to the shorter lengths of stay for youth in out of home treatment settings, which the service system is experiencing. Census data derived from point in time reporting indicate a downward trend for youth in out-of-home settings, showing that there are less youth overall across the state out-of-home on any given day in the month. These data indicate that progress is being made by the Family Guidance Centers in reducing out-of home time for youth

through consistent clinical review of utilization of any youth receiving treatment in an out-of-home setting. Altogether these data seem to suggest that a slightly higher proportion of youth receive services out of their home, but do so for shorter periods of time.



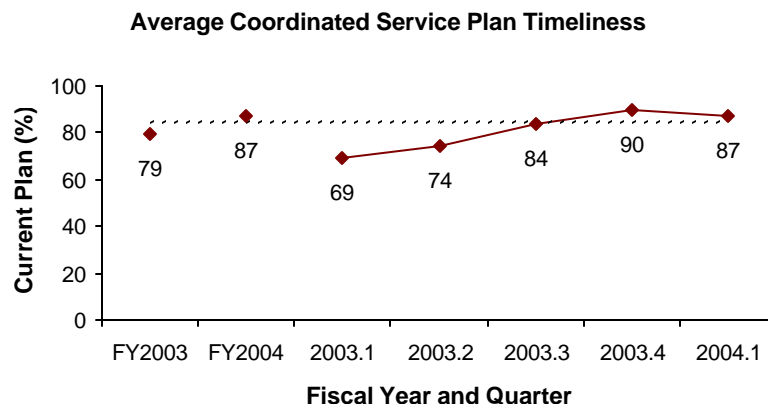
Note: Because FCLB provides many direct services rather than procuring services, these proportions are expected to have greater variability and the mean levels are not directly comparable to the other centers.

CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

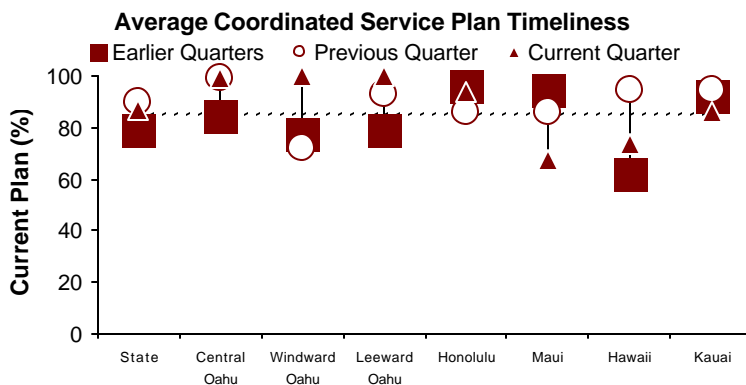
⇒ 85% of youth have a current Coordinated Service Plan (CSP)*

CAMHD's performance in this measure met the performance goal for the reporting quarter as 87% of youth across the state had a current CSP, slightly below last quarter's average. Current is defined as having been reviewed at a minimum within the last quarter and adjusted or revised to reflect the child's current situation as often as necessary. The strong upward trend in this measure represents continuing concerted efforts by teams to assure a service plan for each youth.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed

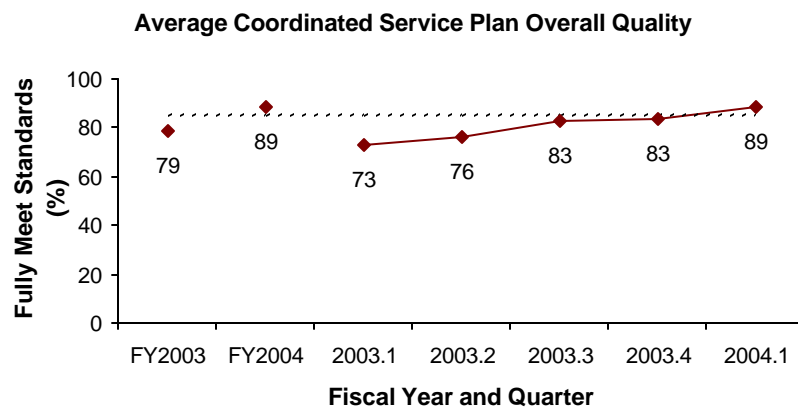
Each Family Guidance Center with the exception of the Maui and Hawaii FGCs met the performance goal. The decline for Maui represents the first time in the past year that the timeliness goal was not met. Maui performance was largely affected by a staffing vacancy and an extended staff absence. This data has been referred to the MFGC Quality Assurance Committee for analysis and development of improvement strategies. The substantive gains made by the Big Island in the last quarter were not sustained for the current quarter. Again, the data was referred to the HFGC QA Committee to be addressed. Improvement strategies are accountable through PISC.



Goal:

⇒ 85% of Coordinated Service Plan review indicators meet quality standards*

Reviews of CSPs against quality standards are conducted quarterly in each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures.



The goal for this measure was met in the reporting quarter with 89% of CSPs sampled meeting overall standards for quality. The achievement of this goal was projected in the last quarter based on the steady improvement over the past year. The goal was met or exceeded by Central Oahu, Windward, Honolulu, and Kauai FGCs. The Big Island (84%) and Maui (82%) nearly met the performance target. Leeward CSP quality has an improving trend, but data indicate a need for improvements in this area.

Mental Health Services will be provided by an array of quality provider agencies

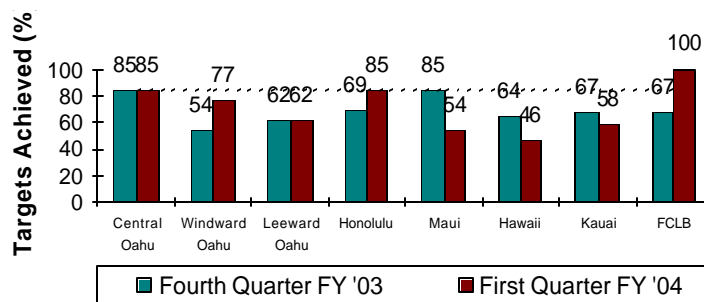
Goal:

⇒ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, grievances, access to services (service gaps/mismatches, least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting 85% of the performance indicators was met by Central Oahu, Honolulu and Family Court Liaison Branch (FCLB) FGCs. This is the second quarter to date that all goals have been met by two or more FGCs. On average across all FGCs, 70% of all goals were met in the quarter, compared to 68% in the last quarter, and 55% in the first quarter of FY 2003. Any performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed through their internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. The FGC management team tracks the implementation of each improvement strategy.

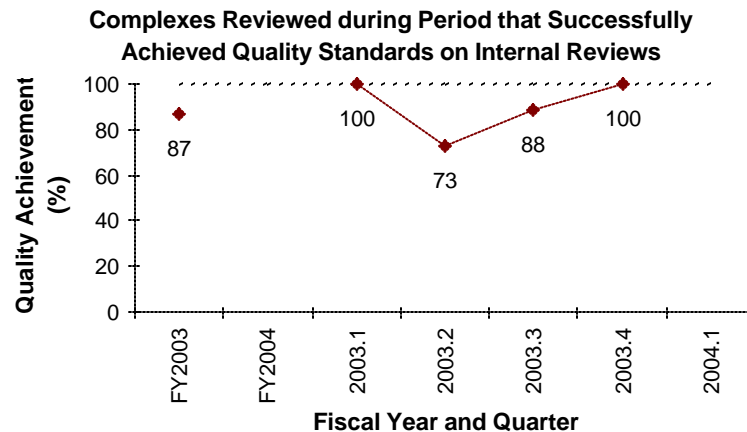
FGC Performance Indicators Successfully Achieved



Goal:

- ⇒ 100% of complexes will maintain acceptable scoring on internal reviews*

No complexes were reviewed in the first quarter as reviews commenced starting in October 2003. Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance.

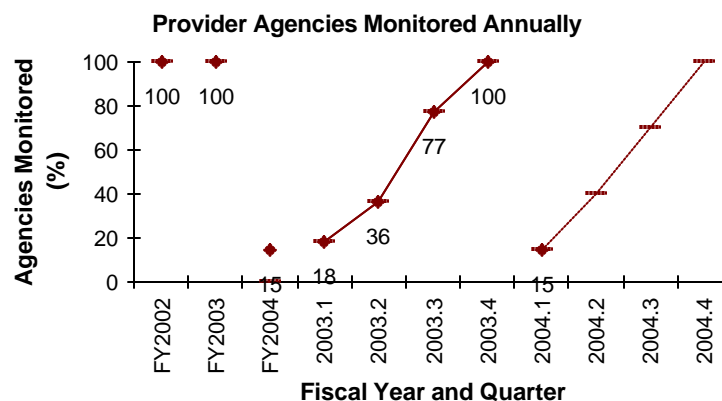


Mental Health Services will be provided by an array of quality provider agencies

Goal:

- ⇒ 100% of provider agencies are monitored annually

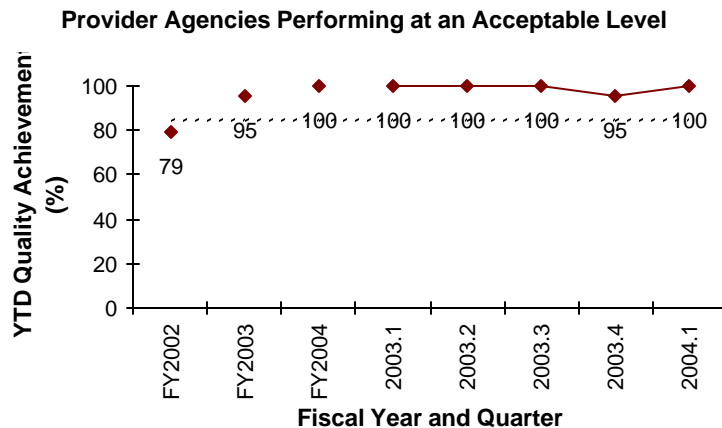
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Programmatic reviews, including case-base reviews, allow for a focused examination of safe and effective practices. In the quarter, 100% of all agencies contracted to provide direct mental health services were monitored as scheduled. Three agencies, representing ten contracts and seven levels of care, were monitored in the quarter.



Goal:

- ⇒ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 100% of the provider agencies reviewed were found to be performing at an acceptable level, meeting the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices.

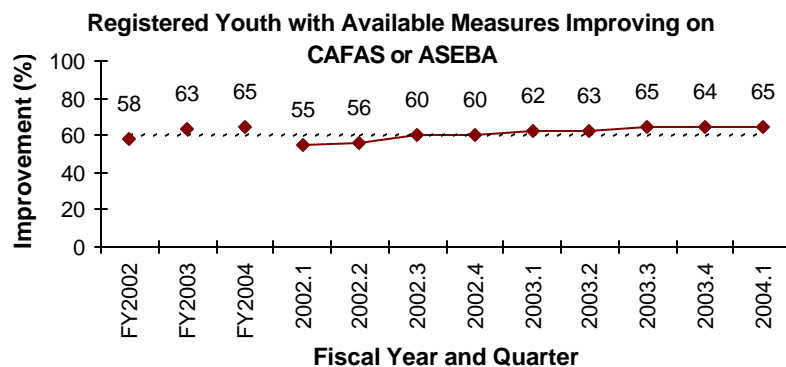


CAMHD will demonstrate improvements in child status

Goal:

- ⇒ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and Achenbach (ASEBA) for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.

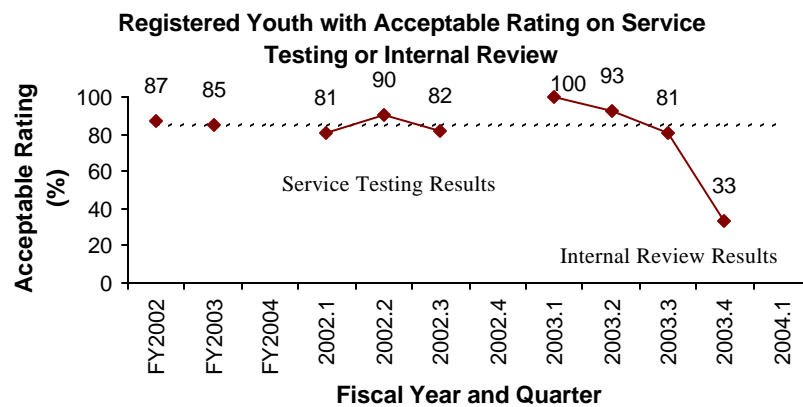


In the reporting quarter, for youth with data for these measures, 65% of youth were showing improvements since entering the CAMHD system, which meets the performance goal. There has been a steady upward trend in functional improvements for youth served by CAMHD. Child functioning as measured by these scales has improved by 5% since the end of FY 2002.

Goal:

⇒ 85% of those with case-based reviews show acceptable child status

No complexes were reviewed during the quarter.



Families will be engaged as partners in the planning process

Goal:

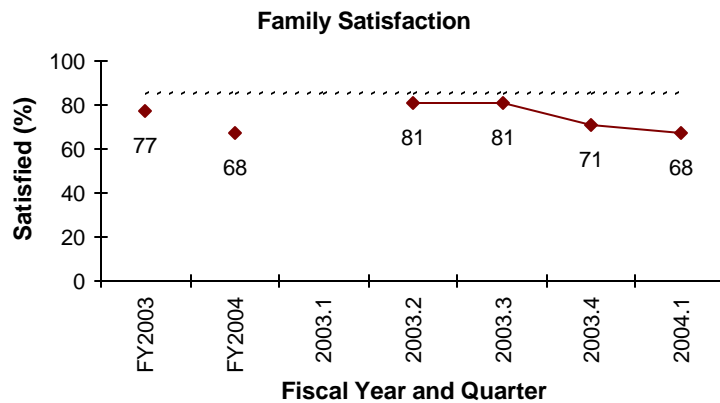
⇒ 85% of families surveyed report satisfaction with CAMHD services

CAMHD had selected this measure to gauge family engagement in the planning process and satisfaction with services. Although not a core sustainability measure, CAMHD remains fully committed to family involvement at all levels of its program. In the past family and youth satisfaction information has been collected through the CAMHD family organization partner, Hawaii Families as Allies. As seen, 68% of families surveyed were satisfied with services received in the reporting quarter, which does not meet the goal.

Although the observed satisfaction rates are decreasing, further analysis suggested that this trend was not statistically significant using a 95% confidence rate. Thus differences in scores across quarters may be due to chance fluctuations in the survey samples. Therefore, at the present, it may be concluded that approximately 75% of families report satisfaction with CAMHD services, and that the specific quarterly estimates vary due to the survey's margin of error.

CAMHD has decided to change its consumer survey process for FY 2004. Rather than surveying families quarterly in collaboration with HFAA, CAMHD will hire a professional, NCQA certified health

research vendor. Several factors promoted this decision. First, more and more families have refused to complete the survey as they have been contacted multiple times within the year. Second, Med-Quest Division is requiring administration of the Experience of Care and Health Outcomes (ECHO) survey on an annual basis for Quest-involved youth. CAMHD expects that the use of the ECHO survey with the NCQA protocol will provide higher quality, albeit less frequent information on family perceptions.



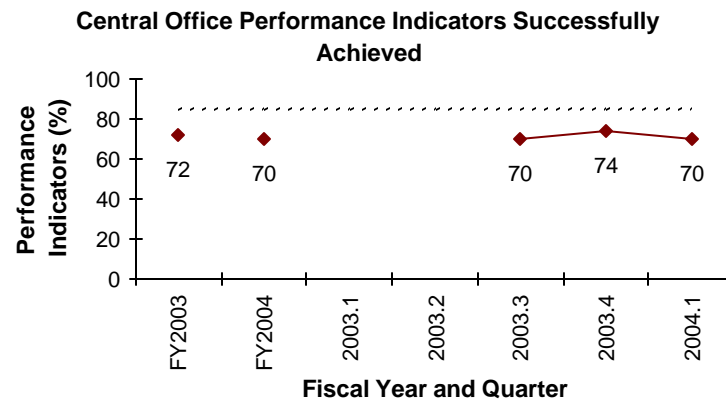
There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇒ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section under the Clinical Services, Performance Management and Administrative Offices as an accountability and planning tool. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT), and are reported monthly or quarterly depending on the measure. A total of thirty-five measures are tracked. Performance results and trends are discussed and strategies are developed to sustain or improve performance. There are a total of 37 measures currently tracked by EEMT. Over time, measures may be graduated, and new measures selected based on strategic initiatives and priorities of the organization.

In the reporting quarter, 70% of measures were successfully met. Note that last quarter's data was incorrectly reported as 68% of indicators successfully met, and is corrected in this report at 74%. For each indicator that falls below its performance target, the managers in the respective section examine results. Improvement strategies are established and tracked for implementation. For example, when monitoring reports are not completed within timelines, the performance measure for the Program Monitoring Section, the manager must assess all variables impacting the measure. If solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.



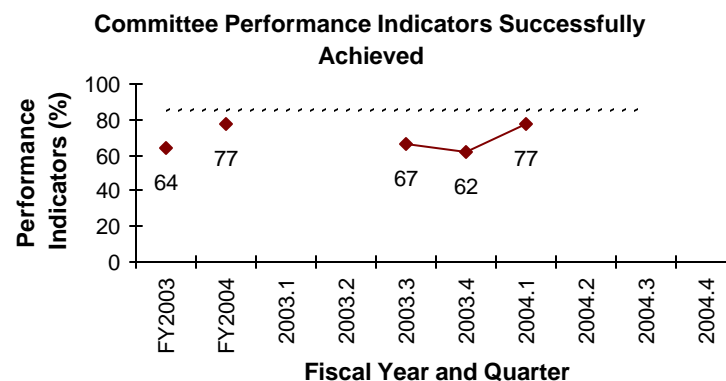
Benchmarks were initially set somewhat above current performance levels to promote quality improvements. Representative of a functioning quality improvement system, when benchmarks are continuously achieved over a period of time, measures will be vacated for new performance targets.

Goal:

⇒ **85% of CAMHD State Committees performance measures will be met.**

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of thirteen measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to select specific improvement strategies that are implemented by respective CAMHD section managers.

In the quarter 77% of performance goals were met through the work of the CAMHD Committees, 15% higher than last quarter's results of 62% of measures achieved. Focused improvement initiatives have had an impact on improved performance in a number of areas.



Summary

The majority of performance goals were met or exceeded in the fourth quarter. The asterisked measures are those linked to demonstration of sustainability of efforts under the Felix Consent Decree process. Of the sustainability measures, all indicators fully met the performance goal in the reporting quarter. The areas of strength continued to be all measures regarding maintenance of infrastructure, funding, timely access to services, system responsiveness to stakeholder concerns, and quality service provision.

The following were measures that met or exceeded goals:

- Filled care coordinator and central office positions*
- Care coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Youth receiving services within 30 days of request*
- Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:*
- Youth with no documented complaint received
- Provider agencies with no documented complaint about CAMHD performance
- Youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Central, Honolulu and FCLB FGC performance goals
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The indicators newly meeting performance goals were Coordinated Service Plan quality, and Honolulu and FCLB FGCs meeting goals. Considerable gains have been made across the state in assuring quality Coordinated Service Plans.

Two measures had no data due to the Internal Reviews schedule:

- Child Status as measured by Internal Review Results
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*

The following measures demonstrated a stable or improving trends, but did not achieve the targeted goal:

- Provider agencies with no documented complaint received (2% below target)
- Family Guidance Center performance indicators
- Central Office performance indicators

The following measures were below-targeted performance with observed decreases that were not statistically significant. None are Sustainability measures:

- Contracted providers paid within 30 days
- Youth receiving treatment while living in their homes
- Family Satisfaction

For each measure below its targeted goal, a full analysis of factors affecting performance is routinely conducted, and recommendations for improvement are implemented through PISC and the CAMHD management team.

A continued trend in the reporting period is the demonstration of significant sustainability of services and service-delivery infrastructure. All measures of sustainability were fully met. Performance management of service delivery and infrastructure has been infused into the daily operations of CAMHD at all levels. Given current practices and system commitments, CAMHD has been able to provide a stable, vital system of children's mental health services.